Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOCTORS HOSPITAL AT RENAISSANCE
5501 SOUTH MCCOLL RD
EDINBURG TX 78539-9152

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-11-1078-01

MFDR Date Received
November 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "payment made on services was not in accordance with TDI rule 134.403. . . . total payment does not equal what should be paid."

Amount in Dispute: $6,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Bill correctly reimbursed, with $0 addtl payment due."

Response Submitted by: Hoffman Kelley, 5316 Highway 290 West, Suite 360, Austin, Texas 78735

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2009	Outpatient Hospital Services	$6,600.00	$1,743.60

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
5. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - B12 – SERVICES NOT DOCUMENTED IN PATIENTS' MEDICAL RECORDS.
   - 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - 275 – THE CHARGE WAS DISALLOWED; AS THE SUBMITTED REPORT DOES NOT SUBSTANTIATE THE SERVICE BEING BILLED.
   - 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION.
   - 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
   - 899 – IN ACCORDANCE WITH CLINICAL BASED CODING EDITS (NATIONAL CORRECT CODING INITIATIVE/OUTPATIENT CODE EDITOR) COMPONENT CODES OF COMPREHENSIVE SURGERY: MUS CULOSKELETAL SYSTEM PROCEDURE (20000-29999) HAS BEEN DISALLOWED.
   - 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
   - 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER, WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
   - 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.
   - 5036 – COMPLEX BILL - REVIEWED BY MEDICAL COST ANALYSIS TEAM - UR/JE
   - 5056 – PREAUTHORIZATION NOT OBTAINED.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. May the respondent's newly raised denial reasons or defenses be considered?
3. Are the respondent's denial reasons for procedure code 29888 supported?
4. Are the respondent's denial reasons for procedure code 29999 supported?
5. Are the respondent's denial reasons for procedure code J2405 supported?
6. What is the applicable rule for determining reimbursement for the disputed services?
7. What is the recommended payment amount for the services in dispute?
8. Is the requestor entitled to reimbursement?

Findings

1. The self-insured employer reduced or denied disputed services with reason code 45 – "CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT." Review of the submitted information found no documentation to support that the disputed services were subject to a contractual fee arrangement between the parties to this dispute. Neither party submitted a copy of a contract between the health care provider and either the self-insured employer or a network to which the self-insured employer had been granted access. No documentation was found of any notice to the healthcare provider, in the time and manner as required by 28 Texas Administrative Code §133.4, that the self-insured employer had been granted access to the health care provider's contracted fee arrangement with any applicable network during the time the disputed services were rendered . The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Nor has the respondent supported this denial reason. Consequently, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. The respondent's position statement presents several new explanations, denial reasons and defenses that were not previously found in the documentation, as submitted, that had been presented to the requestor prior to the filing of this medical fee dispute. Per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was submitted to support that these denial reasons were ever presented to the requestor prior to the date the request for MDR

was filed with the Division and the other party. Therefore, any newly raised defenses or denial reasons shall not be considered. Only the above-enumerated reason codes will be considered in this review.

3. The self-insured employer denied procedure code 29888 with reason codes 197 – "PAYMENT DENIED/ REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION," and 5056 – "PREAUTHORIZATION NOT OBTAINED." Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the case of an emergency or "preauthorization of any health care listed in subsection (p) . . . that was approved prior to providing the health care." No documentation was found to support a medical emergency, nor was any documentation found to support that this surgical service had been preauthorized. The insurance carrier's denial reasons are supported. Reimbursement is not recommended.
4. As stated above, only the denial reasons presented to the requestor prior to the filing of the request for medical dispute resolution will be considered in this review. Review of the submitted documentation finds that, prior to the filing of the request, the self-insured employer denied payment for procedure code 29999 citing reason codes W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT;" 97 – "PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED;" 193 – "ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME;" 243 – "THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED;" 285 – "PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THE REDUCTION;" and 1014 – "THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED." No documentation was found to support that this service is bundled or included in the payment for another service or procedure. Review of the submitted documentation finds that the above denial reasons are not supported; therefore, procedure code 29999 will be reviewed for payment according to applicable Division rules and fee guidelines.
5. As stated above, only the denial reasons presented to the requestor prior to the filing of the request for medical dispute resolution will be considered in this review. Review of the submitted documentation finds that, prior to the filing of the request, the self-insured employer denied payment for procedure code J2405 citing reason codes W1 – "WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT;" 193 – "ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME;" and 802 – "CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE." Review of the submitted documentation finds that the above denial reasons are not supported; therefore, procedure code J2405 will be reviewed for payment according to applicable Division rules and fee guidelines.
6. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.
7. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75
   - Procedure code 80053 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services

for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $15.44. 125% of this amount is $19.30

- Procedure code 86592 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $6.23. 125% of this amount is $7.79
- Procedure code 86703 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $20.02. 125% of this amount is $25.03
- Procedure code 85027 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $9.45. 125% of this amount is $11.81
- Per Medicare policy, procedure code 29876 may not be reported with procedure code 29880 billed on the same claim. Payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that modifier 59 is not supported. This service was performed on the same knee in the same anatomical location and during the same encounter as the primary procedure. Separate payment is not recommended.
- Procedure code 29880 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $1,035.64. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,812.89. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $1,812.89. This amount multiplied by 200% yields a MAR of $3,625.78.
- Procedure code 29999 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $1,943.12. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,165.87. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $1,035.64. The non-labor related portion is 40% of the APC rate or $777.25. The sum of the labor and non-labor related amounts is $1,812.89. The cost of these services does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $906.45. This amount multiplied by 200% yields a MAR of $1,812.90.
- Procedure code 1400 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0170 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J1030 has a status indicator of N, which denotes packaged items and services with no

separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2270 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of K, which denotes nonpass-through drugs and biologicals paid under OPPS with separate APC payment. These services are classified under APC 0768, which, per OPPS Addendum A, has a payment rate of $0.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $0.14. This amount multiplied by the annual wage index for this facility of 0.8883 yields an adjusted labor-related amount of $0.12. The non-labor related portion is 40% of the APC rate or $0.10. The sum of the labor and non-labor related amounts is $0.22 multiplied by 4 units is $0.88. Per 42 Code of Federal Regulations §419.43(f) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, drugs, biologicals, and items and services paid at charges adjusted to cost are not eligible for outlier payments. The total Medicare facility specific reimbursement amount for this line is $0.88. This amount multiplied by 200% yields a MAR of $1.76.
- Procedure code J2765 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

8. The total allowable reimbursement for the services in dispute is $5,508.12. This amount less the amount previously paid by the insurance carrier of $3,764.52 leaves an amount due to the requestor of $1,743.60. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,743.60.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,743.60, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.